McKeon Strategic Review of Health and Medical Research in Australia

Response to the Strategic Review

from the

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INTRODUCTION

The National Ageing Research Institute Ltd (NARI) welcomes the opportunity to comment on the McKeon review of health and medical research in Australia. By way of background, the National Ageing Research Institute is the largest independent research institute focussed on ageing in Australia, having commenced operations in 1976. NARI has a strong track record of original research, especially in dementia, older age depression, geriatric syndromes including falls, cognitive impairment and chronic pain, as well as evaluation of aged care services within community and institutionalised settings, and it was research for NARI that led to the setting up of the national programme of Aged Care Assessment Team from the mid 1980's. We also have a growing education and professional development program for aged care staff.

NARI currently hosts the Australian Association of Gerontology, has strong links with other Australian and international ageing research organisations and members of staff chair or contribute to a range of government policy committees and research networks. We have a strong consumer involvement with over 500 older volunteers on our register and very strong links to aged care service providers in the acute, sub-acute and long term care sectors. NARI has a multidisciplinary workforce undertaking basic, investigator driven "discovery type" research initiatives, clinical trials, epidemiologic research with longitudinal follow-up, evaluation of aged care services, as well as a comprehensive translational component to many of our research activities.

The McKeon review panel has called for written submissions relating to 4 main questions:

a. *Why is it in Australia's interest to have a viable, internationally competitive health and medical research sector?*
(Terms of Reference 1 and 6)

b. *How might health and medical research be best managed and funded in Australia?*
(Terms of Reference 2, 3 and 7)

c. *What are the health and medical research strategic directions and priorities and how might we meet them?*
(Terms of Reference 5, 12 and 13)

d. *How can we optimise translation of health and medical research into better health and wellbeing?*
(Terms of Reference 4, 8, 9, 10 and 11)

The following discussion will provide comment on each of the 4 questions from the perspective of a smaller, independent medical research institute and with particular reference to strengthening multidisciplinary ageing research, building capacity in this under-developed sector and promoting better translation into policy and practice in order to meet the challenges of our rapidly ageing population. We consider this perspective to be timely given that the terms of reference for the McKeon review recognise that the burden of disease is shifting and that chronic diseases associated with ageing and mental illness are now the leading causes of morbidity and mortality.

Comments on the key questions of the McKeon Review

a. ***Why is it in Australia's interest to have a viable, internationally competitive health and medical research sector? (Terms of Reference 1 and 6)***

It is somewhat ironic that one should even need to ask this question. Australia has an obligation to contribute to advances in health and medical knowledge and is well placed to do so. As a country we provide approximately 3% of published medical research output despite having only 0.3% of the world's population. The output is achieved from a funding budget of just 0.09% of GDP, compared to 0.31% in the USA and suggests a highly effective and efficient use of available research funding. Further investment in health and medical research is likely to increase medical research as a valued export to the international market, whereas inaction will result in the need to import any future advances in health knowledge and technologies at a significantly greater cost.

Maintaining an internationally competitive research culture will ultimately reduce the economic and social burdens of disease as well as improve the quality of health care for all Australians. Moreover, translational research and service evaluation/quality improvement activities necessarily must be undertaken within in the Australian health system if we are to derive any direct benefit from our research outputs. Within this broad context, ageing research must be considered as a priority area for investment, in order to improve our capacity to meet the rapid changes in health needs of an ageing population.

b. ***How might health and medical research be best managed and funded in Australia?*** **(Terms of Reference 2, 3 and 7)**

With respect to ageing, the current funding platform for health and medical research is disjointed (i.e. NHMRC funding of investigator driven research versus ARC funding programs versus DoHA targeted programs versus philanthropic trusts versus industry groups) and lacks strategic direction and priorities. For instance, while competitive and merit based allocation of funding must be a feature of any grant program, at present there is limited ability to fund strategic priority areas, such as ageing research. Moreover, current programs (particularly NHMRC) do not consider allocation based on the proportion of health care expenditure associated with a particular health/disease condition. The Federal government spent $7.9 billion on residential aged care in 2009, yet research rarely occurs in the sector and NHMRC funded studies are almost non-existent. A better articulation of key national priority health areas with a corresponding proportion of the total research budget would better meet the needs of our community. A key element of this framework should be both intramural (funding the best centres of research in an area) and extramural research funding streams.

One existing model is provided by the National Institutes of Health in the USA which includes 27 separate institutes, each with dedicated funding for a particular area of health research. Importantly, the budget of the 27 institutes is to some extent proportional to the cost of health care provision for that particular disease/health area.

The model also ensures that each of the 27 priority areas of health research have their own protected budget allocation thereby allowing for continued knowledge growth in that particular area, although scientific merit is still the prime consideration when awarding funding within that area. The use of separate institutes devoted to a particular health area also allows for better integration and coordination of research activities in that health topic.

The National Institute on Aging (NIA) in the USA leads a broad scientific effort to understand the nature of ageing and disease/conditions associated with ageing, and to extend the healthy, active years of life. Started in 1974, it provides leadership in ageing research, training, health information dissemination, and other programs relevant to aging and older people. It has both intramural and extramural research funding streams designed to foster the development of research and clinical scientists in ageing. Most developed countries have a similar agency responsible for the coordination and funding of ageing research efforts, yet Australia is still without a national authority with the dedicated purpose of promoting ageing research and translation of research knowledge into practice. The allocated budget to the NIA was $1,142,337,000 in 2011 representing approx. 3.8% of the total budget for all research activity in the USA. The NHMRC scoping study on ageing research (2002) identified that funding of Geriatrics and Gerontology comprised only 0.6% of the total NHMRC research support budget and in 2009/10 this had increased to just 0.9%. There is a clear need to address the issue of research support that is proportional to aged health care expenditure, to help build capacity in the ageing research workforce and to provide a funding model which better coordinates and integrates research into our rapidly ageing population. While it is not necessary to copy the National Institutes of Health model exactly, the underlying principles of proportional funding dedicated to specific national health priorities would be advantageous.

Health and medical research is currently under-funded relative to our international partners and competitors and there needs to be an increased quantum of money if we are to remain competitive. Health research funding is “siloed” from the health service budget. Nonetheless, there is an increasing drive to better translate research findings into clinical practice and this process must be met from the existing research budget (thereby reducing available funds for discovery type research). The costs of improvement in clinical services should be funded from the health service budget and there should be new, dedicated budget allocations for this specific purpose, if we are serious about research translation. A better coordination of funding allocations should improve outcomes for both health research and health service quality improvement. Industry partner and philanthropic organisations, including large entities similar to those seen on the international stage (i.e. Wellcome Trust, Hughes Foundation) provide another source of potential funds. Development of a national strategic plan for medical and health research could help to facilitate this type of co-investment and ensure a better coordination of all available funding resources.

c. ***What are the health and medical research strategic directions and priorities and how might we meet them?***
(Terms of Reference 5, 12 and 13)

As our focus is on ageing research we will confine our comments to this currently under-developed national priority area. The NHMRC hosted a workshop in October 2011 on progressing Australia's research agenda on ageing well. Over 40 research organisations, including the Australian Association of Gerontology, the Dementia Collaborative Research centres, the current holders of ageing well, ageing productively grants and most academic ageing research centres as well as government representatives and consumer advocacy groups attended. One major outcome of the workshop was to develop an ageing research agenda which included consideration of the following broad topic areas:

(a) Biology and physiology of ageing;
(b) Health problems of advanced old age;
(c) Psychosocial and behavioural factors and issues;
(d) Economic and environmental factors and issues;
(e) Health services research, and
(f) The Community and special population groups.

Over the past 10 years, there have been several NHMRC/ARC strategic funding initiatives targeted at ageing research as a priority. This includes the framework for an Australian Ageing Research Agenda, the ARC/NHMRC Research Network in Ageing Well, and the Ageing Well Ageing Productively Research Grants program. However, this type of strategic funding has been sporadic, non-recurrent and grossly under-funded (<$4 million/10 years) when compared to the proportion of health care expenditure on the provision of community based and residential aged care service delivery (>$21 billion/year). This situation must change if we are to make successful inroads into the health needs of our ageing population.

An additional concern for ageing research relates to the urgent need to build workforce capacity in this sector. Emerging researchers in ageing have extremely limited opportunities for training and placement and there has been no systematic attempt to engage specifically with aged care clinicians and provide integrated training platforms at the sites of services delivery. Incentives for newly trained researchers to remain within the sector are sorely lacking. Financial incentives for effective collaboration between ageing research centres, academic institutions and the health service sector (especially the long term care facilities) are needed to facilitate appropriate training platforms. Such partnerships would improve translation of research findings directly into routine clinical care, improve health service delivery by incorporating a more educated aged care workforce knowledgeable in best evidence based practice and a greater capacity in the ageing research sector.

d. ***How can we optimise translation of health and medical research into better health and wellbeing?***
(Terms of Reference 4, 8, 9, 10 and 11)

Translation of research findings is best achieved when active research is undertaken at a site of health service delivery and involves interested clinical staff in the research activities. Some important government initiatives such as EBPRAC and now EBPAC have greatly assisted in translational research and provide a useful model for future efforts in this important application of research output. NARI was involved in two of these project; one for falls prevention and one for best practice management of pain in residential aged facilities. With appropriate funding, the Australian government could actively facilitate the development of strong links between the aged care service providers (government and non-government) and academic research units. There are a number of advantages on both sides. The links can provide the latest research findings to service providers, and participation in research can improve morale of staff, provide opportunities for consumer involvement in research projects and improve the quality of the services as well as improve the quality of research. Researchers can be more closely aligned with priorities of service providers and have a better understanding of the barriers and facilitators to providing aged care. At present researchers do not have any government support or encouragement in approaching service providers to participate in research, and service providers have little incentive to be involved in research as involvement is not linked to quality improvement or regulation. The government could play a bigger role in encouraging research participation. Involvement in research has the potential to produce cost savings for aged care providers through quality improvement. The teaching nursing home model can be extended to other sectors of the aged care service system such as community care but services need adequate compensation for involvement in teaching and research. The government needs to encourage service providers to understand the valuable role that teaching and research can have in quality improvement in the short term, as well as longer term benefits of contributing to the health of the population as a whole. See also the information on capacity building in the ageing research workforce described in the response to question c) for further information on models to improve direct translation of research findings into routine clinical practice.

Conclusions

Given the ageing population and the expected investment in health and aged care services that this population will require in the future, it is essential that a comparable investment priority be given to ageing research in order to help better manage the chronic diseases of ageing, develop better preventive interventions and to help older Australians to age well. The current funding structures do not meet such strategic national priority driven research needs and the funding model is not suitable to encourage better coordination of research efforts, development of workforce capacity and especially the translation of research findings into better clinical practice. If only a tiny fraction of the health and aged care expenditure were to be devoted to research, evaluation and translation of the knowledge gained through these activities, we could ensure that our aged care system was of the highest quality, most cost effective, and best suited to the needs and preferences of older Australians.

Yours sincerely,

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